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Election views

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ELECTION VIEWS

We asked a range of contributors what they think the key election issues are for the NHS and their personal hopes for the future under the next government



Martin Marshall, clinical director and director of research and development, Health Foundation

My simple message for the next government is to be clear about your role and stick to it. Your job is to convey a clear and consistent vision of what the health service needs to look like in the future. This is a vision that is centred on a commitment to continuous improvement in population health and in the quality and safety of patient care; that promotes a new dynamic between patients and health professionals and a new model of professionalism; that encourages innovative technologies to enable better communication, improved diagnosis and treatment, and more effective use of limited resources; and that challenges traditional structures and working practices.

Don't tinker, and don't pretend that you can control from the centre. Much has been achieved in the past decade, but we are still a long way from ensuring a self-improving system that can guarantee a high quality experience and excellent outcomes. This can be delivered only by those who work in the service. Setbacks are inevitable when people are taking risks and learning new ways of doing things. Your job is to support those who are leading change. The end result will be a health service that will truly be the envy of the world.

Jacky Davis, co-chair, NHS Consultants Association

While the mantra "free at the point of need" remains sacrosanct, the drive to have NHS care delivered by

competing private sector companies is increasing. This important change—which will profoundly alter the nature of the NHS—has received little critical scrutiny from the media. The Conservatives and Liberal Democrats are overtly in favour of "any willing provider" of NHS services. Labour looks confused, having been prevented by the Cooperation and Competition Panel, which it created, from making the NHS the preferred provider.

Politicians have abandoned critical thought in their rush to embrace the free market—and the recent global failure of the market has not dampened their enthusiasm. There is no evidence to support the claim that the commercial sector does it better and cheaper.

The NHS that all the major parties claim to protect will be a logo attached to any willing provider, with all the increased costs, fragmentation, and loss of accountability that we are already seeing. Those who want otherwise have been effectively disenfranchised.

Ann McPherson, medical director, DIPEx Health Experiences Research Group, University of Oxford

The past 13 years have seen unprecedented investment in the NHS after 20 years of drought by previous Conservative governments. I want to see the NHS continue to be properly funded in line with our European neighbours but without privatisation, which will inevitably be a far more expensive alternative. Two other important issues are on-call cover for



primary care and availability of cancer drugs.

Managers, although necessary, should be kept to the minimum needed for efficiency and to prevent wastage. All doctors working in the UK, including those on call, should be trained and proficient in medicine and English to the same high standard that is expected of those trained within the UK.

We should practise evidence based high quality medicine. The National Institute for Health and Clinical Excellence (NICE) has come under fire in recent times, but I want to see it continuing to develop guidelines for treatments. It needs to be able to respond more quickly to new drugs as they come on the market, including cancer drugs. People's experiences of illness also need to be included as part of this evidence.

I would also like assisted dying to be legalised. It should become part of palliative care alternatives and should be a respected patient choice available to those who wish or request it.



Angela Coulter, chief executive, Picker Institute Europe

Voters must decide which party they can trust to maintain and improve standards after the election when funding for health care will be tighter than it has been in over a decade.

We need policies that will take us further towards the fully engaged model set out by the Wanless reports. These underscored the potential to curb rising costs by managing demand more effectively. That must involve

greater emphasis on prevention and early intervention; a willingness to disinvest from ineffective treatments, procedures, and institutions; and more effort to engage patients in their care.

Department of Health documents are littered with references to patient and public engagement, but progress has been disappointingly slow. According to the Care Quality Commission's national patient surveys, nearly half of inpatients and a third of primary care patients want more say in selecting treatments, and very few people with long term conditions receive effective support for self management. Patients are still treated as passive recipients of care, and this paternalism creates dependency, undermines self reliance, and fuels demand for unnecessary and sometimes harmful treatments.

Allyson Pollock, professor of international public health policy, Edinburgh University

The current talk of social insurance and long term care insurance is all a cover for the introduction of private insurers, the late comers in the feast to divide up the NHS spoils. As sure as night follows day, the government and the private sector will find that public funds are not enough and new sources of income will have to be found and new concessions for insurance and patient charges awarded by government.

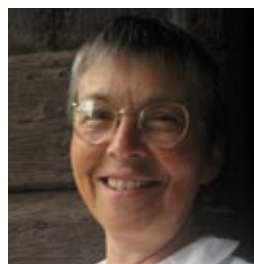
At a time when inequalities are growing the only policy that can work is a return to redistribution. But redistribution is not solved simply by raising income tax; rather it has to be designed into the systems of welfare and delivery to ensure efficiency and equity. And that requires careful attention to the mechanisms of risk pooling and social solidarity. It requires planning and resource allocation on the basis of geographical populations, the elimination of transaction costs such as marketing billing and invoicing, and service integration instead of fragmentation and competition.



There is no evidence to support a market let alone the introduction of commercial providers in health care or welfare; on the contrary, the evidence points the other way. But politicians on all sides have become market fundamentalists mesmerised by short term profit and greed. The BMA campaign, which has hardly registered with the media, was developed in response to members who are observing the devastating consequences of privatisation at first hand on services and on patients.

Iona Heath, general practitioner, London

From the beginning, the very best of medical practice has been built on curiosity, imagination, idealism, vocation, and commitment. All of these are now constrained by policy which, by means of reductive measurements and crude incentives, is attempting to micromanage the interactions between patients and clinicians. The destabilisation of general practice, which began under Mrs Thatcher has already proved extremely costly. In times of severe financial shortage, we urgently need to repair general practice on the clear understanding of the cost effectiveness of holding risk and uncertainty at the level of primary care and referring on for investigations and treatment only when there is a clear likelihood of benefit. Gatekeeping is a much maligned and poorly understood function of primary care, but it has been the foundation of the cost effectiveness



of the NHS since its inception.

What is needed is a policy context that maximises the time that clinical professionals have available to spend in direct patient care; provides an environment within which trusting human relationships can develop and flourish; minimises perverse incentives; avoids the wholesale medicalisation of populations by situating preventive interventions at the level of the society rather than the individual; avoids duplication of effort and expenditure; is prepared to scrutinise the potential futility of interventions towards the end of life, especially in extreme old age; enables primary and secondary care professionals to pool their complementary expertise in the care of patients; and, overall, provides a better balance between the transactional and relational aspects of care. If any party is offering this, just let me know and my vote is yours.



Ian Gilmore, president, Royal College of Physicians

In one respect the outcome of the general election is now beside the point. Whichever party wins, the NHS will have less money relative to rising costs and working practices will have to change.

The real question is how any of the parties will pursue what they both agree to be the main goal—a more productive NHS grounded in a culture of continuous improvement. Greater clinical engagement, a commitment to improving public health, and more space to innovate are certainly welcome motifs. Yet frustratingly, such information as we have on the parties' plans is still mostly at the level of principles while from across the country concerns are surfacing of panicked cuts that belie the politicians' reassuring words.

Service redesign offers the opportunity to reduce activities, control costs, and deliver more care closer to the patient. However, it will also entail closures in some places. Achieving this in the face of local opposition will require an entirely different approach, based on collaboration and visible clinical leadership. The internal market and associated transactional costs, which have done so much to discredit earlier NHS reforms, must also not be allowed to obstruct clinically driven service reconfiguration.

Finally, whoever ends up in the chair at Richmond House will need to be firm in their defence of the NHS against competing government departments. Funding for undergraduate and postgraduate medical training places, audit programmes, and biomedical research could all suffer in the rush to announce savings.

Nigel Edwards, director of policy, NHS Confederation

The key election issue in health is how the NHS can weather the difficult financial environment while maintaining quality. Because of the complexity and contentious nature of this question it doesn't figure much in the manifestos.

My hope is that the NHS can deliver sufficient change to create financial headroom and substantial improvements in quality to avoid what could be a serious crisis within a few years. Most of this change can be made only by front line staff and local organisations. Government can help by removing obstacles and ensuring that policies support change rather than getting in the way. They can tackle the problems with social care funding and provide support for change, including difficult decisions about priorities or the future of some hospitals and other



services. They will also need to exercise restraint in the development of new policy priorities and initiatives.

The way that many services work will therefore need to be fundamentally redesigned—removing complexity, reducing variation, and thinking beyond traditional organisational boundaries. This needs to go beyond easy and often misleading slogans about shifting care into new settings or reducing bureaucracy. Many of these changes will have to be focused not on individual organisations but on the whole system, and above all they need to be designed and led by clinicians.



Nigel Hawkes, journalist, London

As the United States has recently discovered, reforming a flawed healthcare system is extraordinarily difficult, even if its defects are widely recognised. In the UK, the task is made harder still by the presumption that the NHS is part of the Crown Jewels. Politicians advocate reform while insisting that nothing will change: the NHS is safe in our hands. How I long for a politician brave enough to say the NHS is unsafe in our hands. It won't happen, this time or ever.

Given these severe constraints, Labour has proved braver than most since 1997. Its commitment to reform wobbled after Gordon Brown succeeded Tony Blair but continues to flicker in its election manifesto. Most *BMJ* readers probably despise the market oriented reforms Labour has implemented; commentators decry them; think tanks say they have had little effect. But the small degree to which the NHS now recognises patients as customers, with rights and opinions, rather than passive recipients of welfare and health care is to me an index of success. It's called a service, something many of those who work in it are apt to forget.

The Conservatives will not change that, statist as they have become. Changes may appear radical, but their effects will be superficial. The NHS is like an established church, with rigid doctrines, a well rehearsed liturgy, an army of priests and altar boys and cathedrals in the form of hospitals, paid for under private finance initiatives. It begs for a Martin Luther to nail his 95 theses to the door. It hasn't found one yet.

Richard Smith, director, UnitedHealth Chronic Disease Initiative

I'm spending more than three of the four weeks of the election campaign outside Britain—in Mexico, India, and Bangladesh. Viewed from these countries, the problems of the NHS look trivial: it's generously funded, covers everybody, and has strong primary care. What more could anybody ask?

But people do ask for more, and politicians seem obliged to offer more. Nigel Crisp, former chief executive of the NHS, argues in his book *Turning the World Upside Down* that professional, academic, and commercial forces combine to argue that more is better in health care. But it isn't. Alain Enthoven, the American health economist, long ago talked of "flat of the curve health care," where further inputs produced no more benefit, and a point beyond where further inputs mean less benefit and more harm. We may be at that point.

But the poor world is certainly not, and I'd like to see a major shift of resources from rich to poor—rather as happened within Britain when people could no longer tolerate the extreme inequality between rich and poor and income tax was introduced.

I'd also like to see a very serious commitment to tackling climate change. It and poverty render all other problems secondary, but we seem to be going backwards with both.



Kinsh Patel, junior doctor, London

Does this election matter for the NHS? We would all like to think so. But the reality is that whoever gets elected we're all in for a tough time. Cuts used to be a dirty word when it came to health service, but now the parties are competing over who can offer the most swingeing spending reductions. Everyone is offering more of the same. Unfortunately, no one could accuse any of the parties of being radical.

Granted, the past 13 years have seen improvements in health care. But any fool could have delivered that while presiding over huge increases in spending. The difficulty is, of course, delivering improvements without spending more.



The problem with this, however, is that governments of all persuasions have been trying to make efficiency savings for 50 years, with modest success. Sure, there has been tinkering here and there and many initiatives launched. Interestingly, all the reforms have been aimed at supply side efficiency. The big elephant in the room is the demand for health care. What would be truly radical would be to talk about reducing the inexorable demands of health care by introducing a modicum of personal responsibility for health. Let's see if anyone is brave enough to face up to that challenge.

Anne Marie Rafferty, head of school, Florence Nightingale School of Nursing and Midwifery, King's College London

The key challenge for the NHS is building on the track record of success on access and speed and moving towards quick, convenient, and high quality care. A "care-quake" looms with an ageing population of baby boomers combined with an ageing healthcare workforce.

The country faces a care squeeze as much as an economic squeeze, and we



have to innovate our way out of it. This demands creativity, ingenuity, and innovation on a scale we have never seen before. The care continuum is as much about scaling up the capacity of citizens to care for themselves as retooling the healthcare workforce, redeveloping and redeploying it into new roles in integrated care and polysystems.

Keeping older people out of hospital and looking after them well at home presents some of the most complex clinical and organisational challenges of our times. Political will is the first step; forensic focus and investment need to follow.

David Taggart, president, Society for Cardiothoracic Surgery of Great Britain and Ireland

Constraint in the ratio of spending on management to frontline services is mandatory.

The surgical specialties in particular are also concerned about the feasibility of adequately training young surgeons in operative and clinical skills within the confines of the new European Working Time Directive. Furthermore surgical specialties, such as cardiac surgery, that have provided robust national outcome data should have this rewarded through tariffs, which would encourage trusts to collect data on all outcomes and thus drive up standards.

From a personal perspective I would like to see the NHS managed by a



professional body independent of political parties that can take a long term strategic view. I also think that each clinical specialty should have a chief of service who is responsible for both the clinical outcome and financial probity of a unit, as happens in most other countries. And finally, surgeons should spend more time in the operating room. It is not cost effective to have highly trained surgeons spending only one or two days a week in the operating room (analogous to British Airways using pilots to staff check-in desks rather than fly).

John Appleby, chief economist, King's Fund

There is perhaps an unnoticed dividing line between the two main parties on future NHS funding that needs some clarification from both Labour and the Conservatives. Alastair Darling has stated that for 2011-2 to 2012-3, 95% of NHS funding will have a cash rise equal to inflation. The implication for the overall budget is that it will be cut in real terms from between a very small amount up to 5% over two years. The Conservatives pledge that they will give the NHS a real rise—but have not said how much, even approximately, nor what must be given up elsewhere to provide the money.



Whatever the result of the general election the NHS will have to plan (as it is doing) for a radical overhaul of the way it provides care in order to get more from every health care pound. The politics, let alone the practicalities, of NHS service reorganisation are fraught. Politicians need to be supportive of attempts by the NHS to improve productivity—even when the going gets tough and local services in their constituencies face change.

Tighter budgets will inevitably prompt calls from some quarters for alternative ways to fund health care. As

in the past, these should be resisted. Universal services paid for collectively according to income secure the widest possible funding base and public commitment and adhere to the public's desire for equity in health care.



Jennifer Dixon, director, Nuffield Trust

The general election period will be full of political knockabout relating to who will protect funding levels into the future, who won't close local hospitals, who will keep waits for patients down, and who will cut red tape and bureaucracy the most. It will be tedious; expect little serious discussion or much clarity in policy.

Under the next government, the huge challenge will be addressing the potential gap between demand for care and funding—officially £15-20bn over 2011-4 on a £110bn annual budget—in a way that delivers better quality care. Cuts and making efficiencies as done in the past won't be enough. There needs to be a fundamental reorientation of NHS funded care to prevent ill health and reduce avoidable hospital admissions, particularly for people with chronic conditions. For this group unplanned hospital admission should be viewed as failure of care.

I would like to see proactive integrated care developing across primary and hospital care providers and between NHS and social care, all with the firm aim of helping people stay well and reducing avoidable costs. The ingredients for success will be putting patients' interests first; encouraging provider networks rather than commissioners to take on the financial risk (and benefits) of a hard budget on behalf of their registered population; good patient information across the network on costs, quality, and use that is peer reviewed; physicians who are

committed to improving quality and reducing cost and tackling poorly performing colleagues taking lead responsibility; well aligned financial and non-financial incentives within the network towards quality; a shared system of governance that is clinically led; and time and space.

Chris Ham, chief executive, King's Fund

The key election issues for the NHS centre on how it can build on the real progress made since 1997 in the next stage of reform. With funding certain to be much more constrained than in the past, there will be major challenges in holding on to the gains of recent years, such as shorter waiting times, let alone implementing newer promises. The emphasis will have to shift from providing more of the same to doing things differently.

Innovation will be at a premium and the next government will have to be ready to support radical changes in how services are delivered. This includes planning for a future in which less reliance is placed on acute hospitals and more investment is made in primary care and community health services. New models of care will have to be developed by both the independent sector and the NHS to make care closer to home a reality.

My hope is that the next government learns three lessons from the recent past in taking forward reform. Firstly, improving the performance of the NHS is complex and there are no magic bullet solutions. Politicians need to use a judicious mix of targets, regulation, and competition if they are to move performance from good to great.

Secondly, many of the biggest challenges in the NHS require organisations to work together in local systems of care. Examples include reducing inappropriate use of hospital



beds and improving the coordination of care for people with complex needs. Cooperation not competition holds the key to tackling these challenges.

Thirdly, increasing efficiency depends on moving all organisations up to the standards achieved by the best. This means equipping doctors, nurses, and others with the skills and information they need to reduce variations in clinical practice. The next government needs to unleash the energy and commitment of front line staff to improve care in a way that has never been achieved before.

Max Pemberton, doctor and Telegraph columnist

If anything is to be left of the NHS for future generations, the next government must do everything possible to put health care back into public ownership and terminate the financially crippling and inequitable private finance initiative (PFI) contracts.



The introduction of a "mixed economy of care" is the greatest assault on the NHS since its inception and represents a lamentable shift in the way health care is funded. PFI is not a partnership between the public and the private sectors but a set of contractual relationships, the result of which is the insidious and piecemeal transfer of ownership of national resources into the hands of corporate conglomerates. Profits are invariably placed before patients, accountability is lost, and costs spiral. It cannot be allowed to continue.

For psychiatry in particular, the next government needs to think carefully about the current crisis facing the profession. At present, over 85% of trainees entering the profession are from overseas, and posts are increasingly difficult to fill. Serious questions need to be asked

as to why UK medical graduates are turning away from psychiatry. De-professionalisation has resulted in a weakening and destabilising of the role of doctors within mental health and subsequent poor morale.



Neil Graham, medical student, University College London

What is certain in the next parliamentary term? First of all, despite their protestations, the baby boomers will become increasingly grey haired. Secondly, the demand for expensive, new drugs in the NHS will continue to grow.

The result is that the cost of care can be expected to rise more rapidly than inflation, leaving far behind the sums offered for health by any of the main parties. The discussion on health reform has so far been remarkably limited, given the size of the task ahead.

At its heart is the need to take care from hospitals into the community, in order to focus on preventive medicine. Such a change will be unpopular (nobody likes having to travel further to hospital), but to offer existing services at a substandard level would be far worse.

Bold changes in some areas will allow other strengths of the current system to be continued. Losing that which remains of consistency in the doctor-patient relationship in primary care, for instance, would seem too high a price to pay for efficiency.

How can all this take place without putting patient safety on the line? Universal goals should let us build a baseline of quality, quantity, and efficiency of care, as well as guaranteeing standards of education and training. These need to be grounded in good evidence and transparently arrived at.

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